DD Form 2870 Instructions

Block 1: Full name in (Last, First, Middle Initial) format

Block 2: Date of birth in (YYYYMMDD) format

Block 3: Provide full SSN or DoD ID #

Block 4: Provide either a specific date or date range for requested medical records ("ALL" not accepted)

Block 5: Check the block that indicates whether requested records were outpatient, inpatient, or both.

Block 6: This is the facility that will be releasing the medical records. If you are requesting records from

BACH, it will be shown as follows:

Blanchfield Army Community Hospital

If you are requesting from an outside facility/organization, this block needs to reflect that facility/organization name.

Block 6a: This will be the name of the individual/facility/organization we will be releasing the medical records TO. If requesting records for yourself, provide your full name in this block. If another individual will be picking up the records as your personal representative, please provide the full name of that individual in this block.

Block 6b: This block will be the full address of the location we will be mailing records if applicable.

Block 6c: Provide a good contact phone number. This will be used to contact you in the event of any clarification or to notify the individual requesting the records that they are complete.

Block 6d: Provide a fax number, if applicable.

Block 7: Indicate the reason for the request for a copy of medical records. If reason is not listed, ensure “Other” is checked and a reason is specified in the provided block. You can indicate more than one reason for the request.

Block 8: Specify what information is being requested. If you would like only information from a particular clinic ie. Cardiology, EENT, Orthopedic, etc. indicate it in this block.

- All records being sent via secure email will be sent through DoD Safe, a third-party website approved to send Protected Health Information.

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Block 9: Indicate the date you would like this authorization to start being in effect in (YYYYMMDD) format. This will be the date you sign the DD Form 2870 in block 11.

Block 10: Authorization Expiration date (Time period for which this form is authorized to be processed), by default is 1 year from the start date. This date may be shortened but not extended past 1 year.

- Shortening the expiration date may cause the form to expire prior to processing.

Block 11: Ensure a signature of the requesting individual is provided. The signature can be either a wet signature or electronic/digital signature.

Block 12: Relationship to the individual whose records are being requested. If you are requesting your own records, please indicate "Self" in this block.

Block 13: Indicate the date in (YYYYMMDD) format. This is the date the signature was applied to the DD Form 2870.

Blocks 14-16: These are for STAFF USE ONLY. Do not provide any information in these blocks.

Block 17: Signature acknowledging that the request may take up to or more than 60 days due to backlog.

A scanned copy of a government issued ID card, valid state issued ID card, driver's license, or a passport) must accompany any medical records requests that are submitted via email, fax, or mail.

E-mail address: ***usarmy.campbell.medcom-bach.list.pad-roi@healthl.mil***

Office Phone: (270) 798-8389 Fax: (270) 798-8826

or

Mail to:

Defense Health Agency
Blanchfield Army Community Hospital
ATTN: PAD/Release of Information 650 Joel Drive
Fort Campbell, Kentucky 42223